

Homeless
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County of Los Angeles **CHIEF ADMINISTRATIVE OFFICE**

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DAVID E. JANSSEN
Chief Administrative Officer

July 11, 2005

To: Supervisor Gloria Molina, Chair
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

Board of Supervisors
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First District

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Second District

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Third District

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Fifth District

REPORT ON HOMELESS DISCHARGE POLICIES – QUARTERLY REPORT

In accordance with your Board's direction on January 4, 2005, this is to provide a status report of the activities undertaken to date to review the impact of County policies and procedures regarding the discharge of at-risk and homeless persons from County institutions. Specifically, as directed by your Board, the Chief Administrative Office, Service Integration Branch (SIB), has convened a work group composed of representatives from the County's health and human service departments, as well as representatives from Probation, Regional Planning, Sheriff, the Community Development Commission and the Los Angeles Homeless Services Authority, to discuss coordination of discharge practices among County departments/agencies, and enhancement and integration of support services for the benefit of at-risk and homeless people.

Consistent with the May 6, 2005, homeless discharge policies status report to your Board, the above referenced departments continue to meet for purposes of reviewing and developing options in response to unmet needs that will enhance current discharge policies in order to eliminate discharging clients to a homeless state. This review has identified the Sheriff's Department as the agency with the greatest number of clients being discharged on a daily basis. Therefore, a sub-work group has been created to focus on the development of options and approaches to enhance the Sheriff's existing positive discharge assistance program by developing solutions to unmet needs and barriers. Karen Dalton, the Sheriff's Department Director of Correctional Services Division, is chair of the sub-work group.

In addition to the Sheriff's sub-work group, the participating departments/agencies continue to meet and provide updates with regard to current policies/processes, which are incorporated into the attached matrix. Some activities listed in the matrix, as well as other future activities of the Discharge Policies Work Group, include:

- In May 2005, DPSS launched a pilot program that provides case managers to all homeless CalWORKs families to assist them, while on aid, in finding permanent housing. DPSS has targeted July 2005, for County-wide implementation of this program.
- On or before October 30, 2005, DPSS will implement a discharge planning/exit interview process for homeless CalWORKs families to provide them with linkages to appropriate services, including housing, prior to termination. DPSS will provide this same process to non-homeless CalWORKs individuals and families who are at risk of homelessness. Discharge planning/exit interviews are also being explored for all adults exiting General Relief due to time limits.
- If additional staff resources can be provided, DPSS has proposed out stationing additional DPSS staff at the Central Jail to assist individuals exiting from incarceration in applying for CalWORKs, General Relief, Food Stamps and Medi-Cal.
- Explore the development of legislative changes that may be required to address legal barriers in relation to housing stock, rental subsidies, and inmate's rights, to name a few.
- Develop, and cost out, processes to alleviate unmet needs such as rental assistance programs and coordinated multi-disciplinary support services planning.
- Explore the possibilities of including non-County public agencies and private service partners in the Discharge Policies Work Group process.

The Discharge Policies Work Group continues to address the following activities:

- Development of general discharge guidelines with common elements applicable to all departments that discharge clients.
- Address needed modifications to strengthen existing, or create new, discharge policies and procedures.
- Explore the possibility of creating a housing locator data base that would contain information on the location and availability of affordable housing.

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- Consider establishing "housing locator" positions, either County or contracted positions, to be filled by specialists who are trained in locating affordable housing and assisting clients with obtaining such housing.

Finally, the Discharge Policies Work Group is aware that several of the above activities are being explored and/or addressed by other County entities whose membership includes all the departments named in the Discharge Policies Board motion. Therefore, the Discharge Work Group is working to ensure that duplication of effort is minimized and that the accomplishments of the Work Group serve to contribute to the work of the other groups, e.g., the Prevention and Mainstream Systems Work Group of the Bring Los Angeles Home Blue Ribbon Panel, and various work groups contributing to the Mental Health Services Act planning process.

We will continue to provide updates in the quarterly reports requested by your Board. The next quarterly report will be provided in October 2005.

If you have any questions or need additional information, please contact me, or your staff may contact Michael D. Castillo at (213) 974-4652 or mdcastil@cao.co.la.ca.us.

DEJ:LS:MDC

Attachment

c: Leroy D. Baca, Sheriff
David B. Sanders, Ph.D., Department of Children and Family Services
Carlos Jackson, Community Development Commission
Thomas Garthwaite, M.D., Department of Health Services
Marvin Southard, DSW, Department of Mental Health
Bryce Yokomizo, Department of Public Social Services
Paul Higa, Probation Department
James E. Hartl, Regional Planning
Cynthia Banks, Community and Senior Services
Mitchell Netburn, Los Angeles Homeless Services Authority

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

DEPT.	PROGRAM/ POPULATION SERVED	DESCRIPTION / BACKGROUND	STRATEGIES/RECOMMENDATIONS
DCFS		Mission: Will, with our community partners, provide a comprehensive child protection system of prevention, preservation, and permanency to ensure that children grow up safe, physically and emotionally healthy, educated and in permanent homes.	
DCFS	Family Preservation and Section 8 Housing Vouchers Population: Families receiving family preservation services	<p>Since 1999, DCFS has partnered with the Housing Authority of the City of Los Angeles (HACLA), the Housing Authority of the County of Los Angeles (HACoLA), and the Santa Monica Housing Department Family Unification Program from Housing and Urban Development (HUD) to expedite the processing of Section 8 housing vouchers to families receiving Family Preservation (FP) services. Additionally, within the scope of FP, families have an opportunity to access auxiliary funding for certain limited housing purposes.</p> <ul style="list-style-type: none"> ➤ Resources: Family Preservation Auxiliary Funds. ➤ Purpose: Used to pay the first month rent and/or security deposit with the intent of maintaining stability within the family. ➤ Program Requirements/Services Provided: Upon assessing that the family is in need of housing, the Children's Social Worker (CSW) submits a request to the DCFS FP Program Manager for approval/denial. ➤ Capacity: <ul style="list-style-type: none"> a. Total amount available Countywide: \$1,302,400 b. Number of families receiving family preservation auxiliary funds: <ul style="list-style-type: none"> ▪ FY 2002-03, 317 families ▪ FY 2003-04, 390 families ➤ Barriers: <ul style="list-style-type: none"> a. Auxiliary funds are capped and are used to provide a full range of FP services; funding to secure housing is only one of the services. b. Decreased Section 8 funding from HUD has made collaboration with the City of Los Angeles no longer viable for DCFS. <p>DCFS has an agreement with the HACoLA to set aside 300 Section 8 vouchers for families receiving FP services and to expedite the processing of these vouchers. Continuation of the Section 8 voucher set aside is not guaranteed given the reduction in Federal Section 8 funding.</p>	Develop strategic partnerships/collaborations with other County departments that have resources to assist in the continued development of services to keep youth and families in safe, secure, and stable housing.
DCFS	Independent Living Program (ILP)/Emancipation Services (ES)	DCFS' ILP/ES Program, via their Emancipation Services Division, provides emancipation services to prepare and assist youth to live successfully on their own. Transitional Coordinators support children's social workers in the development of Transitional Independent Living Plans (TILP) for youth to ensure a smooth transition out of foster care and into adulthood. Preparing youth for living on their own and identifying potential homeless youth are two of the functions of the TILP.	

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

DEPT.	PROGRAM/ POPULATION SERVED	DESCRIPTION / BACKGROUND	STRATEGIES/RECOMMENDATIONS
	Population: Foster care youth, current and former, between the ages of 14 and 21.	<ul style="list-style-type: none"> ➤ Resources: FY04-05 ILP allocation is \$16,249,129; Youth Stipend allocation is \$1,709,303; it is anticipated that the FY05-06 allocations will be similar to FY 04-05. ➤ Purpose: To prepare youth to live independently on their own. ➤ Program Requirements/Services Provided: Emancipation services are delivered in a coordinated effort by transition coordinators located in each regional DCFS office and in the nine Transition Resource Centers throughout the County. Emancipation services include, but are not limited to, Early Start to Emancipation Preparation services for 14 and 15 year old youth; life skills training classes for 16 – 20 year old youth; vocational skills classes to prepare youth for trades; job skills services; college preparation and assistance; and, rental assistance for up to three months. ➤ Capacity: Eligible youth receive services to the extent funding is available. 	
DCFS	Transitional Housing Program (THP) Population: Emancipated foster, and probation youth 18 to 21-years-of-age at risk of becoming homeless	<p>DCFS' Transitional Housing Program is funded through 11 Federal HUD grants. Participants reside in apartments scattered throughout the County. Fair market rental rates are paid for most one- and two-bedroom apartments. A few apartments, however, are rented below market value as they are owned by the County's Community Development Commission, leased by the United Friends of the Children and rented to the THP. Rental rates for these below market units range from \$330 to \$750. The units are not available for permanent housing as they are used to provide ongoing transitional housing for program participants. Supportive services are provided by DCFS Case Managers. It must be noted that THP is a "program" and <u>not a housing only resource</u>. Residents <i>must</i> be <i>willing</i> to participate in the required program services.</p> <ul style="list-style-type: none"> ➤ Resources: Federal HUD Grants ➤ Purpose: Provide short-term transitional housing to emancipated foster and probation youth who are at risk of homelessness and provide opportunity for the youth to save enough money to move into permanent housing. ➤ Program Requirements/Services Provided: The program requirements include, but are not limited to, attending weekly life skills classes, school and/or working full or part-time, saving a required percentage of their earned income in an interest-bearing trust fund (which is returned to them upon completing or exiting from the program) used to secure and maintain permanent housing, and adhering to other behavioral rules of the program. Failure to adhere to the THP's requirements/rules within a reasonable amount of time results in termination, as allowing non-complying participants to remain in the program jeopardizes future grant funding. Terminated 	<p><u>THP Terminated participants:</u> Resources other than THP must be identified / developed for homeless youth falling into this category.</p> <p><u>General THP participants:</u></p> <ul style="list-style-type: none"> a. Set aside or develop affordable housing for this population and age group. Youth cannot be expected to secure and maintain permanent housing if rental expenses far out-pace their earning potential upon discharge. b. Financial and housing resources must be developed to ensure the availability of affordable permanent housing for discharged youth, if they are unable to find housing on their own. Youth under these circumstances are currently referred to shelters and are urged to consider tapping into additional resources and supports including relatives.

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

DEPT.	PROGRAM/ POPULATION SERVED	DESCRIPTION / BACKGROUND	STRATEGIES/RECOMMENDATIONS
		<p>participants can appeal or file a grievance if they disagree with their termination. The Appeal and Grievance policies/procedures are mandated and approved by HUD and the Los Angeles Homeless Services Authority (LAHSA).</p> <ul style="list-style-type: none"> ➤ Capacity: The program has a maximum capacity of 244 participants. ➤ Barriers: <ul style="list-style-type: none"> a. Many participants only want housing and are not interested in participating in other program requirements. For example, participants are unwilling or unable to maintain stable employment and generate enough savings to obtain/maintain permanent housing. b. The lack of available affordable housing, particularly for this population and age group; thus, money saved is often inadequate for permanent housing. c. THP HUD grants do not provide funding for aftercare services or housing resources. Once a youth ages out of the program, DCFS is unable to provide any financial assistance. 	
DCSS		<p>Mission: To assist residents in obtaining self sufficiency; strengthen and promote the independence of older persons; provide employment and training for unemployed adults, displaced workers, seniors, and young people; protect and assist adult victims of abuse; provide safety and security for domestic violence victims; and, develop services that are needed within local communities.</p>	
DCSS	<p>Adult Protective Services (APS)</p> <p>Population: Elderly and disabled persons over 21 years of age</p>	<p>APS contracts with 22 licensed residential care facilities County-wide to serve both elderly and dependent adults who are at risk of homelessness. These facilities are used to provide emergency housing as a last resort and time limited basis, providing the client is willing and able to accept placement and has no other immediate financial resources. APS workers also rely on clients' friends and family as potential housing resources and can issue emergency transportation vouchers. In less urgent situations, the APS social worker works with the client to assist in preventing eviction, or in locating low-income/subsidized housing. In cases where homelessness is a potential, the APS worker may make a referral for a mental health assessment and/or a referral for probate conservatorship.</p> <ul style="list-style-type: none"> ➤ Resources: State General Funds Revenue via DPSS; DCSS' approximate annual allocation for the APS program is \$25 million, of which \$250,000 is used for emergency housing. ➤ Purpose: To investigate reports of abuse, neglect, or exploitation of elderly and dependent adults and in some cases provides emergency shelter and housing referrals for elderly and dependent adults. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. The APS downtown Los Angeles Civic Center unit serves homeless elderly and disabled adults daily. If the clients are drug and alcohol free, they may be referred to a 	<p>In cases where potential homelessness exists, emergency housing arrangements does not adequately meet the housing needs of this population. What is needed is more stable, service-enriched, long-term housing options, such as those projects currently being considered/developed under the auspices of the Special Needs Housing Alliance (Alliance).</p>

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

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		<p>contractor SRO (single room occupancy) for housing. On an emergency basis, clients may be referred to Cold Weather Shelters and, if the client remains in contact, tracked so that more stabilized housing assistance can be provided.</p> <p>b. The majority of APS cases do not involve homelessness. However, there are a number of instances when an elderly person or dependent adult is threatened with eviction. The APS program can provide emergency housing for up to 30 days.</p> <p>c. In cases of imminent eviction or homelessness, APS can respond within the same day and has the capability to roll-out 24 hours per day, seven days per week.</p> <p>➤ Capacity: In FY 2003-2004, the APS Program placed 105 elder and dependent adult clients who were temporarily homeless in safe shelter until more permanent housing could be arranged. APS projects that about 110 clients will be placed in emergency housing in FY 2005-2006.</p> <p>➤ Barriers: Unwillingness by the client to receive services.</p>	
DHS		Mission: To improve health through leadership, service, and education.	
DHS	<p>Alcohol and Drug Program Administration (ADPA)</p> <p>Population: Persons with substance abuse dependency</p>	<p>ADPA residential service agreements require contractors to develop a basic core of residential alcohol and drug services, which include conducting an intake and comprehensive assessment of the participants' physical and emotional health; alcohol and/or drug use; and vocational/educational, legal, housing, family/interpersonal, and recreational needs.</p> <p>➤ Resources: State General Funds (Alcohol and drug); Federal Substance Abuse, Prevention, and Treatment (SAPT) Block Grant Funds; Federal Drug/Medi-Cal funds.</p> <p>➤</p> <p>➤ Purpose: To eliminate the homeless potential for persons being treated for drug/alcohol dependency before reaching the discharge phase of their rehabilitation program.</p> <p>➤ Program Requirements/Services Provided: Each contractor is required to prepare a treatment plan for each participant and, if homelessness is an issue, housing is incorporated into the plan. Sixty days prior to discharge, participants are provided with multiple alternative housing resources including, but not limited to, transitional housing, satellite housing, and sober living homes. Prior to discharge, this information is reviewed and a Residential Exit Plan is prepared to assist the participant in selecting appropriate housing or, in some cases, reconciliation with family members. All residential program discharge policies require the availability of housing prior to discharge. Program participants discharged prior to their scheduled exit are sent back to the original referral source or are referred directly to other residential treatment programs. ADPA Contract Program Auditors routinely review each program's discharge policies and procedures and review client files to ensure that they contain</p>	

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS **REVISED**

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		<p>the mandated documentation described above. Any departure from these requirements will cause the agency to develop and submit a Plan of Corrective Action to ADPA for approval to remedy the identified problem.</p> <p>➤ Capacity: Approximately 2,000* beds</p> <p><i>Summary of Residential Treatment vs. Homeless Status for FY 2003-04</i></p> <table><tr><th>SPA</th><th>Total Admissions</th><th>Total Homeless at Admission</th><th>Total Discharges</th><th>Total Homeless at Discharge</th></tr><tr><td>1</td><td>426</td><td>54</td><td>430</td><td>55</td></tr><tr><td>2</td><td>2,629</td><td>880</td><td>2,376</td><td>810</td></tr><tr><td>3</td><td>1,271</td><td>581</td><td>1,239</td><td>613</td></tr><tr><td>4</td><td>1,432</td><td>959</td><td>1,338</td><td>878</td></tr><tr><td>5</td><td>1,262</td><td>1,086</td><td>1,258</td><td>1,091</td></tr><tr><td>6</td><td>1,201</td><td>378</td><td>1,154</td><td>355</td></tr><tr><td>7</td><td>687</td><td>418</td><td>607</td><td>390</td></tr><tr><td>8</td><td>1,274</td><td>563</td><td>1,231</td><td>541</td></tr><tr><td>Total:</td><td>10,182</td><td>4,919</td><td>9,633</td><td>4,733</td></tr></table> <p>*Committed resources for existing delivery system</p> <p>➤ Barriers: Categorical funds may only be used for alcohol and drug treatment, recovery, education, and prevention services. Funding is not available for post-treatment housing.</p> <p>There is a lack of permanent affordable housing.</p> <p>There are insufficient residential treatment and recovery beds. The demand for services exceeds residential capacity.</p> <p>There are insufficient residential and nonresidential treatment and recovery services for persons with co-occurring disorders.</p>	SPA	Total Admissions	Total Homeless at Admission	Total Discharges	Total Homeless at Discharge	1	426	54	430	55	2	2,629	880	2,376	810	3	1,271	581	1,239	613	4	1,432	959	1,338	878	5	1,262	1,086	1,258	1,091	6	1,201	378	1,154	355	7	687	418	607	390	8	1,274	563	1,231	541	Total:	10,182	4,919	9,633	4,733	
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DHS	Office of AIDS Programs and Policy (OAPP)	OAPP contracts with residential facilities that provide various types of residential care for persons living with HIV/AIDS. Such care includes nursing case management, emergency or transitional housing, non-medical residential care, and substance use treatment residential services. Contractors are required to provide many																																																			

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

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	Population: Persons living with HIV or AIDS	<p>services including, but not limited to: intake, assessment, treatment planning and discharge planning activities.</p> <ul style="list-style-type: none"> ➤ Resources: Ryan White CARE Act and State funds. ➤ Purpose: To provide HIV/AIDS residential care for the following: 1) people who can no longer care for their medical needs at home, 2) people who are homeless and in need of housing, 3) people who need non-medical assistance with activities of daily living, and, 4) substance users who require residential treatment. ➤ Program Requirements/Services Provided: Each Contractor is required to have regular observations and assessments of resident's physical and mental condition, and to provide case management, counseling on HIV, nutrition, consultation on housing, health benefits, financial planning and other community resources. Contractors must conduct intake, assessment and treatment planning activities. The treatment plans must be updated every 3 months. Contractors are required to conduct the following discharge planning activities: linkages to medical, emergency assistance, supportive and early intervention services, services that promote access to support services such as case management, meals, nutritional support and transportation. In addition, Contractors must provide linkage to housing opportunities including, but not limited to permanent, independent, supportive and long-term. ➤ Barriers: Lack of permanent housing resources. 	
DHS	<p>Hospitals, Comprehensive Health Centers</p> <p>Population: Hospital patients and persons who visit clinics on an outpatient basis</p>	<p>DHS provides discharge planning at all of its inpatient and outpatient facilities. Facilities have varying policies/strategies for how discharge planning is conducted, however the methodologies are similar.</p> <ul style="list-style-type: none"> ➤ Resources: N/A ➤ Purpose: To ensure that patients are discharged to a safe and appropriate environment. ➤ Program Requirements/Services Provided: There are several points during inpatient or outpatient visits that patients with psychosocial needs including homelessness are identified: upon admission, when seen by a healthcare provider, and throughout the stay. Referrals are made to the Social Work, Utilization Review or Discharge Planning Departments, depending on the staffing/departmental structure of the facility. Discharge planning begins once the assessment of needs has been made by the appropriate department. Inpatient facilities have stringent policies to ensure that patients are discharged to a safe and appropriate environment. Homeless patients are usually discharged to emergency shelters, unless they have medical needs requiring a higher level of care. 	

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

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		<ul style="list-style-type: none"> ➤ Capacity: All inpatient and outpatient clients are screened for discharge planning needs so that they are discharged to an appropriate environment. The “capacity” issue really relates to finding appropriate environments for discharged patients to move into. ➤ Barriers: <ul style="list-style-type: none"> a. Sometimes homeless individuals refuse referrals/placement; b. Not enough resources/affordable housing options are available to provide an appropriate discharge plan (shelters are not always appropriate); c. Data collection systems do not include elements about housing stability or lack thereof; d. No standardized discharge protocol exists for DHS facilities; e. No follow-up on referrals to ensure linkage; f. Healthcare providers emphasize discharge planning to varying degrees; g. Substance abusers are not accepted at many facilities, including homeless agencies; h. Difficult to follow-up with homeless persons to engage them in healthcare; i. Limited resources for undocumented individuals; and j. Many stages during inpatient stays cause discharge planning to be delayed. 	
DMH		Mission: To enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access treatment and support services. (This is the mission if the California health system, which has been adopted by the County DMH.)	
DMH	<p>Child, Youth and Family Program Administration</p> <p>Countywide Case Management Unit</p> <p>Children’s Inpatient Clinical Case Management (CICCM) Unit</p> <p>Population: Foster and probation children and youth who may have mental health issues and are enrolled in Medi-Cal</p>	<p>The CICCM Unit was developed in 1995 with the implementation of Phase I of Medi-Cal consolidation to improve linkage and integration of services between the psychiatric hospitals and the community outpatient system of care.</p> <ul style="list-style-type: none"> ➤ Resources: EPSDT Medi-Cal ➤ Purpose: To provide input on the mental health issues of the population. The DMH case manager’s review of admissions, treatment, and discharge plans for all Medi-Cal clients in the hospital. Case managers participate in treatment conferences, DCFS/RUM (Resource Utilization Management) conferences, and consult with the hospital discharge planners and clinical staff. In addition, charts, Information System (IS) printouts and aftercare plans are reviewed. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. Collaboration and Mental Health Assessment and Link to Services: DMH case managers focus intensive services on children living at home that have not been linked to ongoing outpatient mental health services following one or more hospitalization; participate in interagency DCFS planning conferences for foster children with multiple placements and hospitalizations; and collaborate with and consult with Probation 	Augmenting CICCM staffing resources will provide more intensive and timely consultation services. Increased resource development should be a primary feature of any plan to address potential for homelessness with this population, i.e., including access to in-home mental health services, respite care, increased benefits establishment, and specialized residential placements.

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

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		<p>representatives regarding hospitalized wards of the Juvenile Court who have been hospitalized multiple times.</p> <p>b. Coordination with local system of care: Participation in local mental health planning meetings is another function of the DMH case manager as it is a way to share information and procedures, identify gaps in services and collaborate with other service providers. The DMH case workers have a collaborative working relationship with DCFS regional offices, including participation in MARPRT (Multi-Agency Regional Placement Resource Team); AB 3632 services; System of Care/Wraparound; transitional youth services; and community mental health providers improves service access and integration for clients. The case manager serves as a link for the client between inpatient and outpatient services.</p> <p>c. Discharge Planning: A major role of the DMH case manager is to ensure that appropriate mental health services are provided upon discharge. Case information and the client's aftercare forms are reviewed, and specific Countywide data is collected to track linkage and ensure clients are referred for ongoing treatment. Cases requiring more intensive follow-up are opened on IS so that children and their families can receive additional support, assistance, and follow-up to access services they need following hospitalization.</p> <p>d. Procedures for Discharge: CICC staff participates in interagency discharge planning meetings for children at risk of homelessness. They provide consultation for mental health services and placement options. CICC staff follows the client into the community to ensure that linkage with appropriate mental health services is established.</p> <p>➤ Capacity: 200 per year</p> <p>➤ Barriers: Client discharges are impacted by a lack of available resources in the community, i.e., outpatient mental health clinics, residential placements, lack of funding, lack of specialized services for children with serious medical conditions, and lack of family support/respite care.</p>	
DMH	<p>AB 2034: Comprehensive services to mentally ill persons</p> <p>Population: Homeless mentally ill persons 18 years and older not connected to services and institutionalized in jail</p>	<p>AB 2034 is a State financed program to do "whatever it takes" to provide comprehensive, integrated services to meet individual's needs, which includes housing and employment. This program is designed as a paradigm shift in the delivery of services to homeless, mentally ill individuals.</p> <p>➤ Resources: State AB 2034 Funds and County General Funds</p> <p>➤ Purpose: a) To assist mentally ill clients that are homeless, not currently connected to services (many of whom are incarcerated or have a history of incarceration), to improve their quality of life. b) To prevent mentally ill persons being discharged from institutions to homelessness. c) To provide mentally ill inmates and patients with: residential stability; decreased hospitalizations and incarcerations; increased level of functioning; and increased independence, including</p>	<p>➤ Increase AB 2034 funding and increase the number of AB 2034 recognized agencies.</p> <p>➤ Develop better protocols to ensure releasing institutions notify DMH's AB 2034 staff.</p> <p>➤ Adult Systems of Care (ASOC) is reviewing and developing the discharge planning guidelines for AB 2034/ACT programs that ensure clients are discharged into the community with linkages and referrals to essential housing and other community services and support.</p> <p>➤ The DMH Stakeholder's process for allocation of MHS funds has identified a need to increase system capacity of</p>

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS REVISED

DEPT.	PROGRAM/ POPULATION SERVED	DESCRIPTION / BACKGROUND	STRATEGIES/RECOMMENDATIONS
	or mental health facility	<p>employment.</p> <p>➤ Program Requirements/Services Provided:</p> <p>a. Jail Linkage: Since the creation of AB 2034, DMH has provided an outreach component located in the Twin Towers Correctional Facility Center. The AB 2034 Program staff located in the jail focuses on outreaching to inmates housed in the mental health sections of the jail who have been identified as being homeless at the time of their arrest and those who will be homeless at the time of their release. The AB 2034 Program staff interviews those inmates to determine if they meet the program's criteria for eligibility; and, if eligible, the inmate is referred to one of the 19 AB 2034 agencies in the County. The AB 2034 agency will interview the inmate to ensure program compatibility and begin discharge planning which includes arranging for pick-up at the time of release. The AB 2034 agency will provide immediate and/or transitional housing upon the inmate's release.</p> <p>b. Other Linkages: AB 2034 also provides linkage to housing for patients of residential treatment facilities and hospitals.</p> <p>c. Transportation: AB 2034 agencies arrange for pick-up when AB 2034 eligible persons are discharged from residential treatment facilities, hospitals, and jails in order to ensure that they transition without incident.</p> <p>d. Housing: AB 2034 providers, utilizing flexible funding established in the original legislation, are able to provide emergency, immediate, and transitional housing for participants who would otherwise remain on the streets or in overnight shelters. The funds are used to master lease property that can be used to house participants in lieu of them remaining on the streets. In addition, the funds are used to pay for motel and hotel vouchers. Once participants are placed in temporary housing situations, the AB 2034 providers assist them in securing permanent housing. The flexible funding allows AB 2034 providers to assist participants with move-in expenses, furniture, and other housing related costs.</p> <p>➤ Capacity: 1700 clients per year</p> <p>➤ Barriers:</p> <p>a. There is a greater need for AB 2034 agencies and services than there is available funding.</p> <p>b. Early Release: Although DMH coordinates with the County jails and other inpatient institutions, sometimes clients are released without notification to DMH AB 2034 staff.</p>	AB 2034 and ACT programs.
DMH	County Hospital Adult Linkages Program	ALP's mission is to assist with the coordination of psychiatric services for DMH clients at DHS Hospitals through a DMH County Hospital Liaison assigned to each County hospital.	There is an identified need for increased residential housing options that includes intensive mental health services; adequate

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	<p>(ALP) County Hospital Liaison</p> <p>Population: Patients of County Hospitals</p>	<ul style="list-style-type: none"> ➤ Resources: Funding from County General Funds, Supplemental Security Income (SSI). Four liaisons for the inpatient units and four liaisons for the psychiatric emergency services after April 1, 2005. 2.5 peer advocates are planned for FY 05-06. ➤ Purpose: To ensure that clients being discharged are linked with the appropriate level and type of mental health, residential, substance abuse, or other specialized programs. ALP promotes the expectation that clients must be successfully reintegrated into their communities upon discharge and that all care providers must participate in client transitions. ➤ Program Requirements/ Services Provided: In collaboration with the DHS Hospital Liaison and DMH program management, the DMH County Hospital Liaison: <ul style="list-style-type: none"> a. Collaborates with the DHS treatment teams to assist in developing aftercare plans for clients identified with intensive and complicated service needs. This may include facilitating the submission of required documentation for referrals to long-term residential placements. b. Provides consultation to hospital staff and discharge planners regarding community alternatives available to clients on inpatient units and psychiatric emergency rooms. c. Identifies Intensive Service Recipients (ISR) by Services Areas (SA) and refers them to DMH's SA Impact Teams for linkage to outpatient providers. d. Collaborates with community providers to facilitate linkages to community-based resources. Liaisons attend Impact Team meetings in the designated County Hospital SA and participate in SA Advisory Committee (SAAC) meetings. e. Identifies system barriers, including social and financial barriers, to successful reintegration of clients into their communities, and works with DHS staff and identified agencies and providers to resolve these barriers. f. Participates in the management and allocation of treatment resources among high need populations. g. Participates in the collection of DMH outcome data related to discharges from County Hospitals. ➤ Capacity: Varies. Liaisons are involved with treatment teams in all County hospitals to facilitate linkage to community placements on a daily basis. This averages about 35 per week or 1820 per year. Additional staff in psychiatric emergency services will double capacity to 3640. ➤ Barriers: Barriers include a lack of access to outpatient mental health and medical services for uninsured clients, lack of enhanced residential placements with specialized programs for individuals recovering from substance abuse, adequate levels of interim funding for uninsured clients, and legal issues. 	<p>levels of interim funding; programs in County Hospitals to identify and establish benefits for patients being discharged; and access to outpatient, community-based medical and substance abuse treatment services.</p>

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DMH	<p>Adult Hospital Linkage (AHL) Project</p> <p>Population: Adults and Older Adults with serious mental illness</p>	<p>The AHL Project enhances the “system of care” for individuals that utilize acute mental health hospital services by bringing together diverse stakeholders that play critical roles in the lives of adults and older adults. Implementation of the AHL Project is currently focusing on the needs of ISRs – individuals who have a serious mental illness and have had six or more psychiatric hospitalizations within a consecutive 12-month period.</p> <ul style="list-style-type: none"> ➤ Purpose: <ul style="list-style-type: none"> a. To ensure rapid access and linkage to the appropriate level of care for individuals being discharged from inpatient facilities; b. Prevent further hospitalization when appropriate; and c. Implement new strategies for collaboration between inpatient and community-based services, designed to ensure continuity of care. ➤ Resources: County General Funds, some Medi-Cal ➤ Program Requirements/ Services Provided: <ul style="list-style-type: none"> a. Service Area Impact Units (SAIU) are composed of representatives of programs providing services to ISRs, including outpatient mental health programs (Assertive Community Treatment (ACT), AB 2034) which provides outreach and integrated community-based services to individuals who are homeless and have a mental illness including those who are involved with the criminal justice system, Adult Targeted Case Management Services (ATCMS), and general outpatient programs), Emergency Outreach Bureau, local hospitals, and housing coordinators. As needed, SAIUs also involve representatives of other programs, such as the Regional Center and local residential facilities. b. A key member of the SAIU team is the Hospital Liaison – a DMH staff person who regularly visits local inpatient programs, identifies ISRs, and links them with intensive services. As they identify ISRs hospitalized locally who reside in another part of the County, Hospital Liaisons contact one another in a timely fashion, thereby ensuring successful coordination of care across SA boundaries. c. Presently, SAIUs are beginning to develop crisis management plans with clients and family members that may assist mobile response teams or hospitals in preventing hospitalization or reducing the disruption caused when an admission becomes necessary. ➤ Capacity: Varies over the course of the year, approximately 300 clients were served through 	<p>Stable housing, including specialized residential placements, adequate levels of interim funding, and the expansion of community-based mental health and substance abuse services are needed to assist clients with a serious mental illness who are at risk for homelessness.</p>

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		<p>this project.</p> <ul style="list-style-type: none"> ➤ Barriers: Lack of stable housing and residential care placement alternatives constitute major obstacles to successful community placement of ISRs. A lack of residential alternatives include specialized residential programs for individuals with mental illness who are in recovery, augmented residential treatment placements for individuals who require more intensive mental health services, short-term crisis residential programs, and adequate levels of interim funding for uninsured individuals. There is an ongoing need for more availability of Assertive Community Treatment (ACT) programs in some geographic areas. 	
DMH	<p>Institutions for Mental Diseases (IMD) – State Hospital Transition Project</p> <p>Population: Mentally ill patients of State Hospitals</p>	<p>In July 2004, DMH implemented the Institutions for Mental Diseases (IMD)-State Hospital Transition Project to transition clients from long-term residential settings to community placement with ACT programs. Important components of the project include enhanced IMDs, ACT programs, residential services, and peer support programs. The project has several phases: assessment, placement/linkage, and follow-up.</p> <ul style="list-style-type: none"> ➤ Resources: Supplemental Social Security Income (SSI) and County General Funds. ➤ Purpose: To transition approximately 180 DMH clients safely and successfully from State Hospitals and IMDs to lower levels of care, including independent living, with intensive mental health services. ➤ Program Requirements/Services Provided (Discharge Planning Procedures): <ol style="list-style-type: none"> a. IMD Administration staff identified and referred 80 clients in State Hospitals and 267 clients in IMDs with the potential for discharge readiness and determined the level of care required on discharge from June 17, 2004 to the present. b. Based on assessment, clients were referred to enhance IMDs from the State Hospitals or community placements with ACT programs. c. Clients determined to be ready for discharge from IMDs were referred to ACT programs for community placement. ACT team members met with IMD staff, clients, and conservators to develop discharge plans that included residential placement and mental health services based on the needs of individual clients. d. Interim funding for residential placements was made available by the IMD Administration for IMD clients who were without funding resources. e. Peer support services were an important component of the plan and were incorporated into each IMD program. Peer “bridgers” assisted in preparing clients while they were in the IMD for the community, and provided support and linkage to community peer resources after discharge. f. Outcome measures were established to monitor the progress of the project including: e rates of re-hospitalization, adverse incidents, readmission to IMDs, incarcerations, and AWOLS (away without leave). 	<p>The transition project identified the need for the development of augmented residential placements with intensive mental health services, including specialized programs, stable housing resources, more ACT and AB 2034 programs, and adequate levels of interim funding to assist in transitioning clients safely and successfully to the community.</p>

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		<ul style="list-style-type: none"> ➤ Capacity: Since July 1, 2004, 180 mental health clients were successfully transitioned from State hospitals and IMDs to lower levels of care. ➤ Barriers: <ul style="list-style-type: none"> a. Increased levels of acuity. b. Lack of available residential beds, including specialized programs for transitional age youth, older adults, forensic, substance abuse, etc. c. Lack of availability of ACT, ACT-like, and AB 2034 programs in some SAs. 	
DMH	<p>Section 8 Shelter Plus Care (S+C) Program</p> <p>Population: Homeless mentally ill clients of County DMH</p>	<p>DMH receives Section 8 S+C Program grants from both HACLA and HACoLA. The program provides eligible homeless DMH clients with a five-year rental subsidy certificate and mental health services to help maintain living independently in the community.</p> <ul style="list-style-type: none"> ➤ Resources: Federal HUD Section 8 Housing assistance vouchers from the City of Los Angeles and the County of Los Angeles. ➤ Purpose: To provide clients with access to affordable permanent housing and ongoing mental health services to maintain living independently in a community setting. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. Rental subsidization certificates for a five-year period (renewable) along with mental health services. b. Clients must meet the HUD definition of homelessness, be capable of living independently in the community, be connected to a DMH outpatient clinic or contract agency with a designated case manager, and agree to continue receiving mental health services. c. Process for applying and receiving funds: Case managers' complete applications on behalf of their eligible clients and the applications are forwarded to the appropriate Housing Authority. Certificates are issued within four to six weeks. Clients have six months in which to find housing. ➤ Capacity: Varies per fiscal year. In 2004, DMH was awarded 85 certificates from the HACoLA and 50 certificates from the HACLA. Approximately 265 clients are currently enrolled in the S+C Program through DMH. Community-based agencies working with the homeless mentally ill also receive separate grants from these and other city housing authorities. ➤ Barriers: <ul style="list-style-type: none"> a. There are a limited number of certificates available for homeless mentally ill clients seeking affordable permanent housing. b. There are not enough affordable housing units available to meet the housing demand. 	<ul style="list-style-type: none"> ➤ Advocate for more Federal funds to support rent subsidization for special needs populations. ➤ Advocate for more Federal/State funds to increase the inventory of affordable housing and, in particular, to provide funding for the necessary supportive services that are critical to accompany such housing.

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		c. The Homeless Section 8 program has been discontinued for the time being by the Federal government, thus limiting the number of rental subsidies available for special needs populations.	
DMH	Rental Assistance Program Population: Homeless mentally ill persons	<p>DMH sets aside funding from its Projects for Assistance in Transition from Homelessness (PATH) grant and other resources to provide first month and security deposit funds to eligible homeless clients moving into a affordable housing or for clients facing eviction. The definition of homelessness depends on the source of the funding, but may include clients moving out of hospitals and board and care facilities into independent living in the community.</p> <ul style="list-style-type: none"> ➤ Resources: Funding comes from DMH's PATH grant, Substance Abuse, and Mental Health Services Administration funds and the Emergency Housing Assistance Program. These are Federal HUD funds. ➤ Purpose: To provide access to affordable permanent housing by covering the initial costs associated with moving into a new rental unit specifically financial assistance with first month rent, security deposit and move-in costs. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. Clients must be homeless, as defined by the funding source, and meet the financial/homelessness eligibility criteria established by HUD, be capable of living independently in the community, be connected to a DMH outpatient clinic or contract agency with a designated case manager, and agree to continue receiving mental health services. b. Process for applying and receiving funds: DMH outpatient case managers complete applications on behalf of their clients. ➤ Capacity: Total amount available varies each fiscal year. In FY 04-05, DMH spent \$123,000 and served a total of 87 clients. ➤ Barriers: There are not enough funds to accommodate the needs of homeless clients who have identified affordable housing but lack the resources to cover the move-in costs. The majority of funding is Federal and requires clients to meet the strict federal definition of homelessness that does not include clients transitioning out of hospitals, board and care facilities and other institutions. 	<ul style="list-style-type: none"> ➤ Advocate for more funds to cover move-in costs for homeless clients who have identified permanent affordable housing and do not have the resources to provide the up-front costs required by all landlords. ➤ Advocate for a more liberal definition of "homelessness."
DMH	Specialized Shelter Bed Program Population: Homeless mentally ill persons who are DMH outpatient	<p>DMH has contracts with shelters that set aside beds for DMH client referrals that are homeless and have no source of funds. Clients can remain in the shelter for a maximum of six months.</p> <p>Resources: The program has an annual encumbrance of \$825,000 of County General Funds.</p> <ul style="list-style-type: none"> ➤ Purpose: To provide temporary shelter and food to DMH homeless indigent clients until they have their benefits established or secure an income and move into affordable permanent housing. 	Advocate for more funds to provide shelter for DMH outpatient mentally ill clients.

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	clients	<ul style="list-style-type: none"> ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. Clients must be homeless, indigent, and associated with a DMH outpatient clinic and have a designated case manager. Clients can stay in the shelter for up to a maximum of six months. b. Process for applying and receiving funds: DMH outpatient case managers contact the respective DMH gatekeeper for each shelter. The gatekeeper approves the enrollment depending upon the shelter's current capacity and must also approve each 30-day extension up to the six month maximum. ➤ Capacity: In FY 03-04, DMH contracted with 15 Shelters a capacity to provide basic living services to approximately 80 clients each month. ➤ Barriers: There are not enough funds to accommodate the needs of homeless DMH clients, particularly families with young children. 	
DMH	<p>Mental Health Court Program (MHCP) Community Reintegration Program</p> <p>Population: Mentally ill persons involved in the criminal justice system</p>	<p>DMH through the Mental Health Court Program's Community Reintegration Programs offers mentally ill defendants community-based treatment as an alternative to incarceration. The program contracts with two mental health facilities to provide comprehensive services to mentally ill persons exiting the legal system.</p> <ul style="list-style-type: none"> ➤ Resources: County General Funds ➤ Purpose: a) To provide mentally ill defendants treatment as an alternative to incarceration b) to reintegrate consumers into the community with the skills and resources necessary to maintain stability c) to reduce recidivism ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a) Collaboration with criminal justice system: MHCP staff work with defense attorneys to refer appropriate candidates and to obtain Community Reintegration as part of the disposition of the criminal case. b) Coordination with Sheriffs Department: MHCP staff facilitate with jail staff the release and transportation of consumers from jail to contract facilities. c) Consultation with Providers: MHCP staff liaison with treatment team and provide input on discharge planning. Discharge plans are based on the needs of the consumer d) Benefits Establishment: Benefits are suspended during incarceration. Specially designated facility staff restore benefits or assist consumers with new applications ➤ Capacity: 70 beds ➤ Barriers: a) lack of housing resources for consumers who not eligible for benefits b) lack of affordable housing c) long delays for community based treatment d) stigma in the community 	Advocate for Increase housing options and for improved access to community-based services.

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		related to population d) lack of specialized housing options with intensive mental health services.	
DPSS		Mission: To enrich lives through effective and caring service.	
DPSS	CalWORKs – Current clients Population: Families and persons eligible for CalWORKs	<p>To assist families exiting a domestic violence situation, eviction, shelter, or general homelessness, DPSS offers the following homelessness prevention services to families as they enter DPSS:</p> <p><u>RENTAL ASSISTANCE TO PREVENT EVICTION</u></p> <ul style="list-style-type: none"> ➤ Resources: CalWORKs Single Allocation funds and Performance Incentive-Net County Cost (PI-NCC) dollars ➤ Purpose: Prevent families from losing their permanent housing. ➤ Program Requirements/Services Provided: Persons receiving funds must be eligible for CalWORKs. ➤ Capacity: DPSS approves about 250 housing vouchers per month for a total of nearly \$160,000. The voucher amount depends on family size, and therefore, the number of families served varies. ➤ Barrier: DPSS uses its Single Allocation “services” and PI-NCC dollars to provide this cash assistance - these are not entitlements. Therefore, the program is only available on a year-to-year basis depending on the availability of funding. <p><u>TEMPORARY HOMELESS ASSISTANCE</u></p> <ul style="list-style-type: none"> ➤ Resources: CalWORKs Single Allocation funds and PI-NCC dollars. ➤ Purpose: Augments the State’s Homeless Assistance Program by providing County Single Allocation funds to extend the time homeless CalWORKs eligible families can stay in hotels/motels for up to 30 days. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. The State’s temporary Homeless Assistance program is limited to 16 days. Additional Single Allocation funding was available in FY 2004-05, and DPSS dedicated \$1.5 million to supplement the State’s program with an additional 14 days, to provide a total of 30 days. DPSS uses its Single Allocation “services” and PI-NCC dollars to provide the additional 14 days, but this is not an entitlement. b. Without the 14-day supplementation, families would be limited to only 16 days of shelter. 	<p><u>Recommendations for CalWORKs Participants:</u></p> <ol style="list-style-type: none"> 1. Expand linkages with other departments and agencies (DCFS, Probation, Sheriff, Courts, Public Defender, DHS, schools, and EDD) to connect families exiting these systems to connect with DPSS services. 2. Provide “life skills” and “money management” classes to families and individuals to better prepare them for exiting DPSS. 3. Intervene with families that include a child age 18. <ul style="list-style-type: none"> ➤ Work with/prepare 18 year olds to transition them to employment. ➤ For families facing discontinuance once the only eligible child turns 18, connect the parent with services that will most quickly lead to employment. 4. Assign case managers to all homeless CalWORKs families to assist them, while on aid, in finding permanent housing. This has been conducted as a pilot since May 2005 and is targeted for County-wide implementation in July 2005. 5. Targeted for implementation in October 2005, DPSS will conduct a discharge planning/exit interview with homeless CalWORKs families to provide them with linkages to appropriate services, including housing, prior to termination. Provide this same exit interview with non-homeless CalWORKs individuals/families that are at risk of homelessness to link them with appropriate services.

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		<p>With the limited continuum of care in the County (i.e., shortage of affordable housing, transitional housing, and emergency housing, etc.), this 16-day limitation restricts the ability of families to find permanent housing.</p> <ul style="list-style-type: none"> ➤ Capacity: DPSS approves over 1,000 hotel/motel vouchers per month for a total monthly amount of nearly \$500,000. ➤ Barriers: <ul style="list-style-type: none"> a. The County supplementation is only available on a year-to-year basis depending on the availability of funding. b. The State limits temporary Homeless Assistance to \$40 per night for a family of four. In Los Angeles County, the average motel stay is nearly always more than \$40, often resulting in families receiving reduced days of shelter. For example, if a family is issued \$280 for seven nights' shelter and they have to pay \$60 per night, they can only afford four days of shelter instead of seven. <p><u>ADDITIONAL INTAKE SERVICES</u></p> <ul style="list-style-type: none"> ➤ Resources: CalWORKs Single Allocation funds <u>and</u> PI-NCC dollars. ➤ Purpose: To expedite/process CalWORKs applications for homeless families. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> a. Outreach to missions/shelters to process CalWORKs applications. b. Outstation eligibility staff at the Weingart Access Center in Skid Row to process CalWORKs applications and requests for housing assistance. c. Supplement LAHSA's emergency shelter system with funding to purchase additional shelter/vouchers, allowing CalWORKs families to have shelter (up to 120 days) while they seek permanent housing. d. Establish a Skid Row outreach team, made up of LAHSA, DMH, and DCFS staff to identify homeless families and link them with services. ➤ Capacity: In FY 2004-05, DPSS used approximately \$1.7 million of its Single Allocation "services" dollars to fund outreach staff and supplement the County's emergency shelter/voucher system. ➤ Barriers: This is not an entitlement program. The ability to provide supplementation funding is only available on a year-to-year basis depending on funding availability. <p><u>RENTAL SUBSIDY</u></p> <ul style="list-style-type: none"> ➤ Resources: CalWORKs Single Allocation funds <u>and</u> PI-NCC dollars. 	

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		<ul style="list-style-type: none"> ➤ Purpose: Subsidizes rent payments to assist (recently homeless) CalWORKs families who have located permanent housing. ➤ Program Requirements/Services Provided: Effective January 2005, DPSS began issuing up to \$250 per month, for up to four months, to help families afford their rent payments. There is not yet any issuance data on this program. ➤ Capacity: Unknown at this time. ➤ Barriers: DPSS uses its Single Allocation "services" and PI-NCC dollars to provide this cash assistance - these are not entitlements. Therefore, the program is only available on a year-to-year basis depending on funding availability. <p><u>PERMANENT HOMELESS ASSISTANCE AND MOVING ASSISTANCE</u></p> <ul style="list-style-type: none"> ➤ Resources: CalWORKs Single Allocation funds <u>and</u> PI-NCC dollars. ➤ Purpose: Pays for security deposits, first and last month rent, etc., allowing families to move into permanent housing. ➤ Program Requirements/Services Provided: CalWORKs-eligible families receive funding to assist them in securing permanent housing. ➤ Capacity: DPSS issues about 500 of these payments monthly for a total monthly cost of nearly \$550,000. ➤ Barriers: <ul style="list-style-type: none"> a. The State's Homeless Assistance program (both temporary and permanent) are once-in-a-lifetime programs - meaning a client can receive only once, with the following exceptions, when homelessness is the result of: 1) a natural disaster; 2) uninhabitability of a dwelling caused by unusual circumstances beyond the family's control, such as a fire; 3) a medically-verified medical/mental illness, excluding alcoholism, drug addiction or psychological stress; or 4) domestic violence. As homelessness tends to be episodic, this limitation restricts the assistance that DPSS can provide in repeated incidents of homelessness. b. DPSS uses its Single Allocation "services" and PI-NCC dollars to provide the Moving Assistance program. This is not an entitlement; therefore the program is only available on a year-to-year basis depending on funding availability. <p><u>CLIENTS EXITING CalWORKs</u></p>	

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		<ul style="list-style-type: none"> ➤ Resources: CalWORKs Single Allocation funds ➤ Purpose: Assisting adults and families exiting CalWORKs due to time limits, employment, or who are at risk of being sanctioned for another purpose to prevent them from becoming homeless. ➤ Program Requirements/Services Provided: <ul style="list-style-type: none"> 1. Adults <ul style="list-style-type: none"> a. Meet with adults scheduled to exit CalWORKs to ensure they are aware of the services available to them which may assist in reducing the risk of homelessness. b. Offer post-employment and post-time limited services, including case management, transportation, child care, ancillary/work-related benefits, and homelessness prevention services (such as moving assistance and rent to prevent eviction). c. Conduct home calls in one pilot region to adults facing sanction in an effort to address barriers and reengage them in GAIN, reducing the risk of homelessness. 2. Families: For families exiting CalWORKs due to total case terminations: <ul style="list-style-type: none"> a. Continued medical coverage for the family. b. Continued food stamp benefits for five months. ➤ Capacity: These services are available to all CalWORKs adults, about 600 monthly, who are exhausting their 60-month time limit. <ul style="list-style-type: none"> ➤ Barriers: DPSS uses its Single Allocation "services" and PI-NCC dollars to support the Moving Assistance program. This is not an entitlement; therefore the program is available on a year-to-year basis depending on funding availability. 	
DPSS	<p>General Relief (GR)/ Food Stamps (FS)/ Cash Assistance Program for Immigrants (CAPI)</p> <p>Population: Refugee who are discontinued from SSI/SSP</p>	<p>DPSS connects eligible refugees whose SSI/SSP benefits have been discontinued with GR/FS/CAPI services.</p> <ul style="list-style-type: none"> ➤ Resources: County General funds and Federal funds ➤ Purpose: Outreach to potentially eligible refugees discontinued from SSI/SSP to connect them with CAPI. ➤ Program Requirements/Services Provided: Cash assistance is provided by the County to refugees that have had their SSI/SSP benefits discontinued. <ul style="list-style-type: none"> ➤ Cash aid to GR applicants to prevent eviction or utility-shutoff. The maximum amount of aid issued for both eviction and utility shut-off is \$136. ➤ For GR applicants who find a job prior to approval, cash aid is available pending their first paycheck. 	<p>Discharge planning/exit interviews are being explored for all adults existing General Relief (GR) due to time limits to ensure they are linked with appropriate services. Conditional upon additional resources, DPSS is also exploring conducting discharge planning interviews with all homeless GR participants.</p> <p>DPSS is exploring expansion of linkages with other departments and agencies (e.g., DCFS, Probation, Sheriff, Courts, Public Defender, DHS, schools, and EDD) to connect families exiting these systems with DPSS services. For example, conditional on additional resources, the department has proposed out stationing additional DPSS staff at the Central jail to assist individuals exiting from jail in applying for CalWORKs, General Relief, Food Stamps and Medi-Cal</p>

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		<ul style="list-style-type: none"> ➤ Food and housing vouchers while GR is pending. ➤ Outreach at Twin Towers to process/expedite GR applications of inmates with mental health issues who are scheduled for release. ➤ SSI advocacy with continued GR payments pending receipt of SSI/SSP. ➤ Welfare-to-work services through the General Relief for Opportunities for Work (GROW), which strives to transition GR participants into the labor market, thus providing an ongoing opportunity to avoid homelessness. ➤ Case management, during which GROW case managers discuss issues affecting participants, including homelessness, and making referrals to available services. ➤ Food Stamp outreach efforts evaluate families' other needs for services, connecting them with other DPSS services, including cash aid/homelessness prevention services to stabilize housing. <p>➤ Capacity: Per SSA, the projected number of refugees in this category is: 1,600 Statewide; of which, 526 are located in the L.A. Metro Region.</p> <p>➤ Barriers: The effectiveness of this outreach is dependent on the Social Security Administration providing a data file of persons living in the County who are scheduled to term off SSI due to the seven year time limit. Pending the data file, a centralized mailing outreach campaign is not possible - only fliers are possible, restricting outreach.</p>	
DPSS	Medi-Cal Medi-Cal Eligible Persons	DPSS outstations staff in private hospitals to take and process Medi-Cal applications from both inpatients and outpatients. The applicants' subsequent approval of benefits contributes to their financial security, thereby reducing the risk of homelessness.	
DPSS	In-Home Supportive Services (IHSS) Population: Elderly and Disabled Persons	<p>IHSS works closely with:</p> <ul style="list-style-type: none"> ➤ Hospitals to determine eligibility and assess service needs of patients that will be discharged to home and to ensure service provider availability. ➤ Adult Protective Services to locate shelter and to plan for long-term housing for recipients in danger of eviction from their home. 	
Probation		Mission: To promote and enhance public safety, ensure victims' rights, and facilitate the positive behavior change of adult and juvenile probationers.	
Probation	Discharge Planning for Probation Foster Youth Population:	When suitable placement is recommended, the Foster Care Case Plan (Probation 1385) and the Transitional Independent Living Plan (TILP) must be completed prior to disposition. When a youth is ordered suitable placement, and suitable placement was not recommended, the Probation Officer has 30 days to complete the Foster Care Case Plan (Probation 1385) and the TILP. These, along with Probation's Judicial Review Court Report, are the documents used to prepare our foster youth for discharge.	Support the development of service-enriched permanent housing for emancipated foster youth with families, such as the Mason Court Apartments Project (described briefly below) currently being developed under the auspices of the Alliance.

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	Foster care youth, current and former, between the ages of 14 and 21, in the Probation system.	<p>The goal of each plan is to reunify the youth with their respective families (when it is viable, safe, and in the best interest of the youth). A concurrent plan for all foster youth is required because many foster youth do not have a tenable family support system. In each case plan, the concurrent plan focuses on permanent alternatives to living with their families. These plans may include long-term foster care, legal guardianship and/or adoption. Emancipation can be a service component if long-term foster care is the permanent goal.</p> <p>Preparing youth for living on their own and identifying potential homeless youth are two of the functions of the TILP. This document is prepared as soon as the youth enters foster care or reaches age 14. The TILP is the second half to our foster case plan and accompanies each Judicial Review Court Report, giving the Court information on the youth's permanent plan and preparedness for emancipation.</p> <p>When housing is identified as a need, the TILP is updated to reflect this and the youth is referred to the Transitional Housing Program (THP) prior to their 18th birthday. The Probation Officer of record will follow the established policy on how and when to refer the youth. Each case is screened and referred to the appropriate providers. When the youth is accepted to a program, the Probation Officer notifies the Court and asks that jurisdiction be terminated. After the Court terminates probation, the youth is transported to the housing program. The department's housing intake coordinator then tracks their entry date and the THP program that the youth entered. The youth remains eligible for services until their 21st birthday.</p> <p>Target Population: Youth that are removed from their homes, are under the supervision of the Probation Department, are suitably placed and considered foster youth.</p> <p>1. <u>EMANCIPATION PROGRAM</u> (formerly known as Independent Living Program for foster youth; Coordinating Memorandum No. 2003-22)</p> <ul style="list-style-type: none"> ➤ Resources: Chafee ILP Funding, Title IV-E Funding, and HUD Grant Funding ➤ Purpose: Preparation for emancipation and post-discharge sustainability in the community for current and former foster youth. ➤ Capacity: N/A ➤ Barriers: <ul style="list-style-type: none"> a. Limited housing resources for ILP eligible youth (850 beds for the entire County). b. Severely limited housing for non-ILP eligible youth (40 beds). c. Non-existent supportive transitional housing for chronically mentally ill youth. <p>2. <u>TRANSITIONAL INDEPENDENT LIVING PLAN (TILP)</u> (Coordinating Memorandum No. 2003-23)</p>	<p><u>Mason Court Apartments Project</u></p> <ul style="list-style-type: none"> ➤ Purpose: To preserve the family unit (emancipated youth with children) by providing safe and stable, multi-department services-enriched housing. ➤ Services include: DCFS FP and emancipation services, room and board, tuition assistance, driving lessons, car insurance etc. ➤ Barrier: Limited to Wards of the Dependency Court.

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		<ul style="list-style-type: none"> ➤ Resources: Title IV-E and Chafee Funding ➤ Purpose: Plan for discharge of foster youth and provide housing/services as they emancipate. ➤ Capacity: All foster youth ages 14 and above. ➤ Barriers: Applies only to foster youth (which represents 10-15 percent of Probation juvenile population). Excludes non-ILP eligible youth with housing needs. <p>3. <u>TRANSITIONAL HOUSING REFERRAL PROCESS</u> (Coordinating Memorandum No. 2003-04)</p> <ul style="list-style-type: none"> ➤ Resources: Title IV-E, Chafee Funding, EDPST Funding, HUD Grant Funding, and AB427 Funding ➤ Purpose: Puts into effect the TILP when housing has been recommended. Provides safe and stable housing for youth after foster care. ➤ Capacity: 852 beds available ➤ Barrier: Only applicable to foster youth and does not address the chronically mentally ill population. <p>See also: Department of Children and Family Services: Transitional Housing Program.</p>	
Probation	<p>Discharge Planning for Residential Treatment and Services Bureau (RTSB) (Camp)</p> <p>Youth who are on probation and living at a juvenile camp</p>	<p>When a youth is under the supervision of the Probation Department and housed at a Probation Camp, the Residential Treatment and Services Bureau is responsible for determining where the youth will live upon discharge.</p> <ul style="list-style-type: none"> ➤ Resources: County General Funds and Temporary Aid to Needy Families Funding ➤ Purpose: To ensure that youth discharged from Probation camps are housed in a safe, stable situation that is authorized by the Court. ➤ Program Requirements/Services Provided: The first choice is reunifying the youth with their families. A home assessment by a field Deputy Probation Officer is conducted prior to the youth's release. If the home is found to be suitable, the parents sign a reunification contract that includes a parental sign-off and agreement to follow the Case Plan. If the field Probation Officer 	

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		<p>finds the home to be untenable or if the family structure has changed and the youth cannot reunite with his/her family, a Change of Plan Court Report is submitted to the Court to identify the youth's need for long-term foster care or emancipation services. The youth is then sent back to Court and ordered suitable placement until the youth can enter emancipation housing or find an alternative permanent plan. The aforementioned policies will then be followed. In 2004, 4,691 Camp Youth were returned to the community.</p> <ul style="list-style-type: none"> ➤ Capacity: Board of Corrections (B.O.C.) rated capacity of 1982 minors. ➤ Barriers: 1. The parent, guardian, or relative is unwilling to take the minor back upon release for various reasons (e.g., minor is considered uncontrollable, etc.). 2. The home situation is determined to be unsuitable for minor upon release due to various issues (e.g., gang activity, drug use, alcoholism, etc.). 	
Probation	<p>Adult Probation Services</p> <p>Adults sentenced to probation by the Court</p>	<p>The Probation Department is responsible for assisting adult probationers in reestablishing and promoting healthy, productive lifestyle.</p> <ul style="list-style-type: none"> ➤ Resources: 131 DPO II positions at \$91,000 per year for a total of \$11,921, 000. ➤ Purpose: To identify the needs of the adult probationer and their family through a strength-based needs assessment in order to promote and reestablish healthy and productive lifestyles ➤ Program Requirements/Services Provided: The emphasis of the Adult Services Bureau is not so much with discharge planning, but with identifying the needs (employment, education, housing, health, etc.) of the probationer during the initial intake process. The focus is then to direct the individual to the available resources (short-term and long-term) that will target those areas identified as critical in stabilizing the individual. This allows for the development of skills (e.g., education, skills training, employment, etc.) necessary to promote a healthier and more productive lifestyle. This process targets the needs of the probationer, as well as the family unit as a whole. Through the use of a strengths-based needs assessment, potential areas of need are identified. Targeted case management then provides referral (individual and family) to service providers within the community to assist the probationer. Cases are monitored throughout the term of the probation and case plans are modified to address the changing needs of the individual. The intended outcome is for the individual to have successfully addressed basic needs while on probation, thereby avoiding any unresolved critical issues at the termination of probation. <p>At the time the Probation Department determines that a probationer no longer represents a direct threat to the safety of the victim or the community, and other conditions of probation have</p>	

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		<p>been met, the Department makes a recommendation to the Court for early termination/reduction of probation term and/or termination/dismissal of probation.</p> <ul style="list-style-type: none"> ➤ Capacity: Serving 20,475 probationers. ➤ Barriers: <ul style="list-style-type: none"> a. Exit interviews are not conducted at the end of probation, as provisions for housing are not ordered by the courts. However, access to housing services are made available through referrals as indicated during probation supervision. Only the conditions of probation are addressed in making a determination for a recommendation to terminate an order of probation. Probationers, however, are required to file current address information on a regular basis throughout their term of probation. b. Although the Probation Department has access to available housing resources (i.e., GR for housing vouchers) and community-based organizations (the Salvation Army's substance abuse recovery homes for temporary or short-term housing, for example), greater interagency collaboration is needed. 	
Sheriff		<p>Mission: To lead the fight to prevent crime and injustice. Enforce the law fairly and defend the rights of all. Partner with the people we serve to secure and promote safety in our communities.</p>	
	<p>Community Transition Unit (CTU)</p> <p>All inmates housed in County jail facilities</p>	<p>The Sheriff CTU's mission is to reduce the likelihood of recidivism or relapse by utilizing comprehensive case management principles with reverence for positive social re-integration and the enhancement of public safety. This is accomplished through collaboration with Correctional staff, Medical and Mental Health professionals, Governmental organizations, Community Based organizations and programs within both public and private entities.</p> <ul style="list-style-type: none"> ➤ Resources: Inmate Welfare Fund ➤ Purpose: To link program participants to appropriate resources, assist participants with re-entry into communities with a focus on preventing vulnerable populations from becoming homeless or criminalized, and to seamlessly transition inmates from custody to the community. ➤ Program Requirements/Services Provided: A needs assessment is conducted and then the inmate is provided comprehensive case management by custody assistants assigned to the respective unit. The following services are offered: <ul style="list-style-type: none"> ➤ The Sheriff oversees the Inmate Welfare Fund, which provides services and supplies for the benefit and welfare of the inmates housed in the LA County jails. ➤ Friends Outside provides case management and transitional services to inmates on contract with the Inmate Welfare Commission. ➤ Veteran's Administration provides outreach and case management to military veterans. ➤ Salvation Army provides case management, job training and life skills to military 	<p>Develop partnerships/collaborations with other County departments that have resources to assist with our diversified population. To continue to seek collaborations with organizations who embrace our clients, seek to assure our discharge plans include linkages to essential housing, and other community services and support.</p>

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		<p>veterans.</p> <ul style="list-style-type: none"> ➤ Volunteers of America (VOA) & the Center for Children of Incarcerated Parents provide Prop 10 services for pregnant and parenting women in custody. Their services extend to the children in the community. ➤ VOA parks a van immediately outside the release area four times a day, within a 24 period, and takes anyone interested in not recidivating into their programs where they are assessed and placed in appropriate programs. ➤ IMPACT Drug Treatment program provides a residential drug and alcohol treatment in the jail. Case managers manage the inmates while in custody and provide supportive services to the individuals who are then placed in either a 12 or 18-month community based drug court program. ➤ The Sheriff's Department has partners with OAPP to provide case management and transitional services for HIV positive inmates. Case managers are placed at each facility within the Sheriff's Department. ➤ The Palms has recently partnered with the Sheriff's Department and will be placing a large treatment based mobile unit near the release area of the Inmate Reception Center. Once in operation, this project will allow any inmate to seek services immediately upon release (with the focus of getting them to test for HIV). Individuals found to be HIV positive can present at the mobile unit and obtain immediate services related to their condition, e.g., medical services, social services, housing, etc. ➤ The Sheriff's Department Correctional Services Unit operates the Religious & Volunteer Services Unit (RVSU) where over 1,200 volunteers provide 12-step meetings, religious services, etc. In addition, the CTU is informed on a regular basis of the RVSU's efforts to transition inmates directly from custody to recovery homes or religious based programs. ➤ The Passport to Learning program is provided to developmentally disabled inmates, which includes transitional services for those inmates who choose to participate. ➤ The Department of Mental Health is co-located in the Twin Towers Correctional Facility and provides treatment, case management, and follow up services to the nearly 2,000 mentally ill inmates in our custody. <p>➤ Capacity: All inmates who are housed in county jail facilities are eligible for re-entry services.</p> <p>➤ Barriers:</p> <ol style="list-style-type: none"> a. Current funding allocation for the Inmate Welfare Fund only supports program for 6 days a week, 16 hours per day. b. Much of the information needed for successful re-entry is sensitive in nature. The lack of trust on the part of inmates is an obstacle we attempt to overcome by asking the questions at different junctures while the client is incarcerated. We seek to pose the questions in a confidential manner to assure truthful responses and to preclude 	

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		<p>embarrassment due to their conditions.</p> <p>c. One of the biggest obstacles for transitioning individuals from custody who are homeless is the lack of available housing in the county. Coupled together with the fact that the Stuart McKinney act does not provide funding or services for anyone who has not been homeless for 24 hours and jail (or incarceration) is not considered homelessness, finding housing is nearly impossible. Many of our inmates transition to emergency shelters and often are lost in the shuffle at that point.</p>	

Revised: 06/23/05 MDC